

FILED DEC 12 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36005

State File No.

BIRTH NO. REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 320

1. PLACE OF DEATH a. COUNTY ADAIR				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY SULLIVAN			
b. CITY OR TOWN KIRKSVILLE		c. LENGTH OF STAY (in this place) 1 MONTH		c. CITY OR TOWN MILAN		1050	
d. FULL NAME OF HOSPITAL OR INSTITUTION GRIM-SMITH MEMORIAL HOSP				d. STREET ADDRESS (If rural, give location) NONE			
3. NAME OF DECEASED (Type or Print) JOHN		a. (First) WESLEY		b. (Middle) CORDRAY		c. (Last)	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH OCT 7, 1967	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 83		11. BIRTHPLACE (State or foreign country) MISSOURI	
13a. FATHER'S NAME SINGETON CORDRAY		13b. MOTHER'S MAIDEN NAME KATHERINE WALKER		14. NAME OF HUSBAND OR WIFE UNKNOWN		12. CITIZEN OF WHAT COUNTRY? U.S.A	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME Taken from Hospital Record		ADDRESS Milan	
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis				INTERVAL BETWEEN ONSET AND DEATH 2 years?			
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				4222			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. auricular fibrillation				1 year			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct 30, 1950 , to December 1, 1950 , that I last saw the deceased alive on Dec 10, 1950 , and that death occurred at 11:15 AM , from the causes and on the date stated above.							
23a. SIGNATURE [Signature] (Degree or title)				23b. ADDRESS Kirksville Mo		23c. DATE SIGNED 12-1-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE DEC 3, 1950		24c. NAME OF CEMETERY OR CREMATORY KNIFONG		24d. LOCATION (City, town, or county) (State) BROWNING MO	
DATE REC'D BY LOCAL REG. Dec 1-50		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS Milan Mo	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEC 12 1960

Date Received: DEC 6 1960
DISTRICT HEALTH OFFICE #2
District File Number 12-50-206
Date Filed: DEC 8 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Samuel C. Rogers

Licensed Embalmer No. 3292

P. O. Address Melrose

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.